UNDERSTANDING THE ENHANCED OUTPATIENT PROGRAM: INSIGHT INTO THE PROGRAMMING AND SERVICES AVAILABLE TO EOP PATIENTS

Mental Health Training Unit | Statewide Mental Health Program
Division of Health Care Services | California Department of Corrections and Rehabilitation

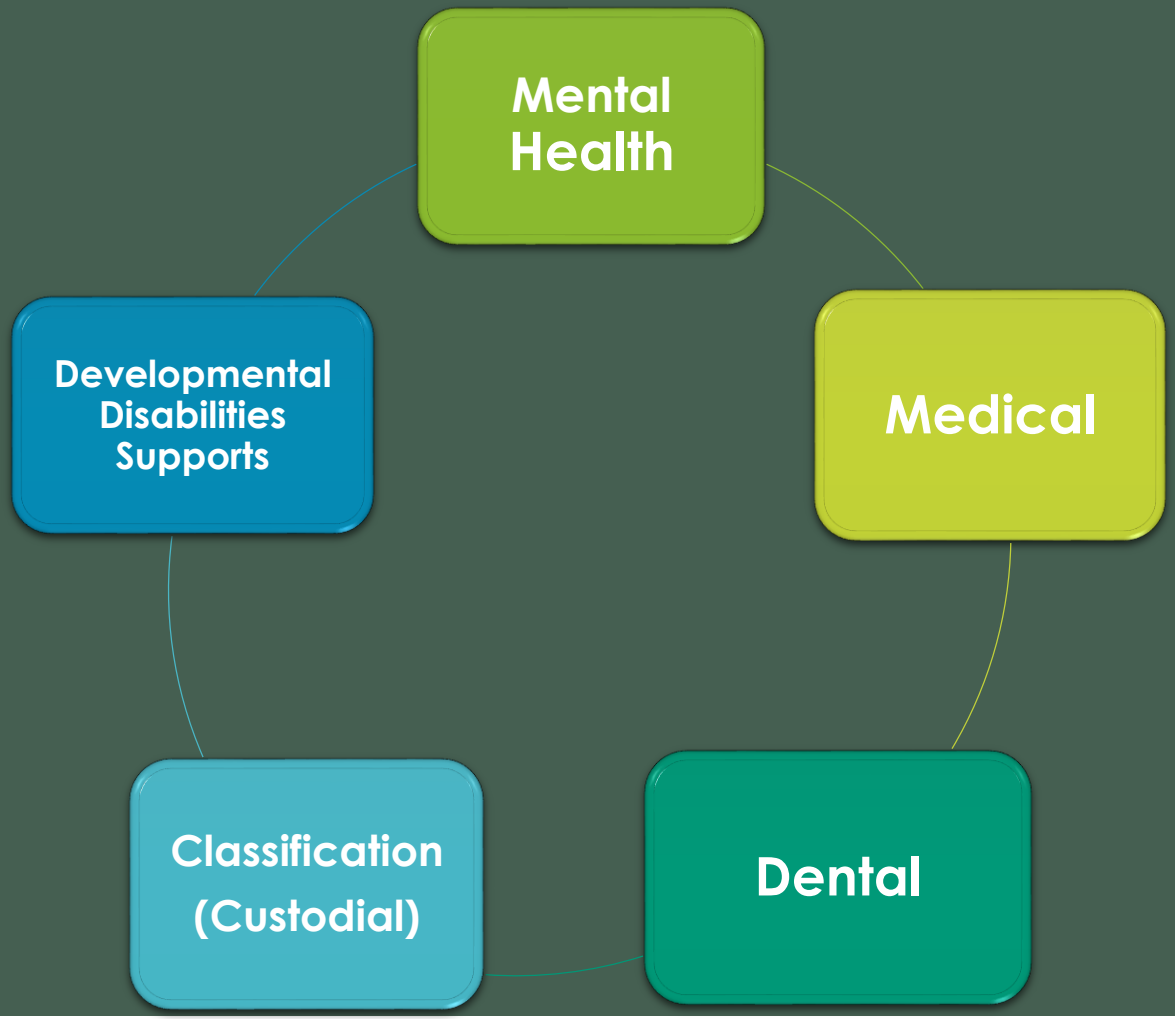
Learning Objectives

1. Briefly identify the major goals and treatment criteria of the Mental Health Services Delivery System (MHSDS)
2. Provide an overview of the Enhanced Outpatient Program (EOP), its purpose, how it functions, treatment issues, and treatment services offered
3. Briefly describe the core components and tasks of the Interdisciplinary Treatment Team (IDTT) and Level of Care changes
4. Discuss Pre-Release Planning for patients in the EOP

LEARNING OBJECTIVE 1

Briefly identify the major goals and treatment criteria of the Mental Health Services Delivery System (MHSDS).

Reception Centers



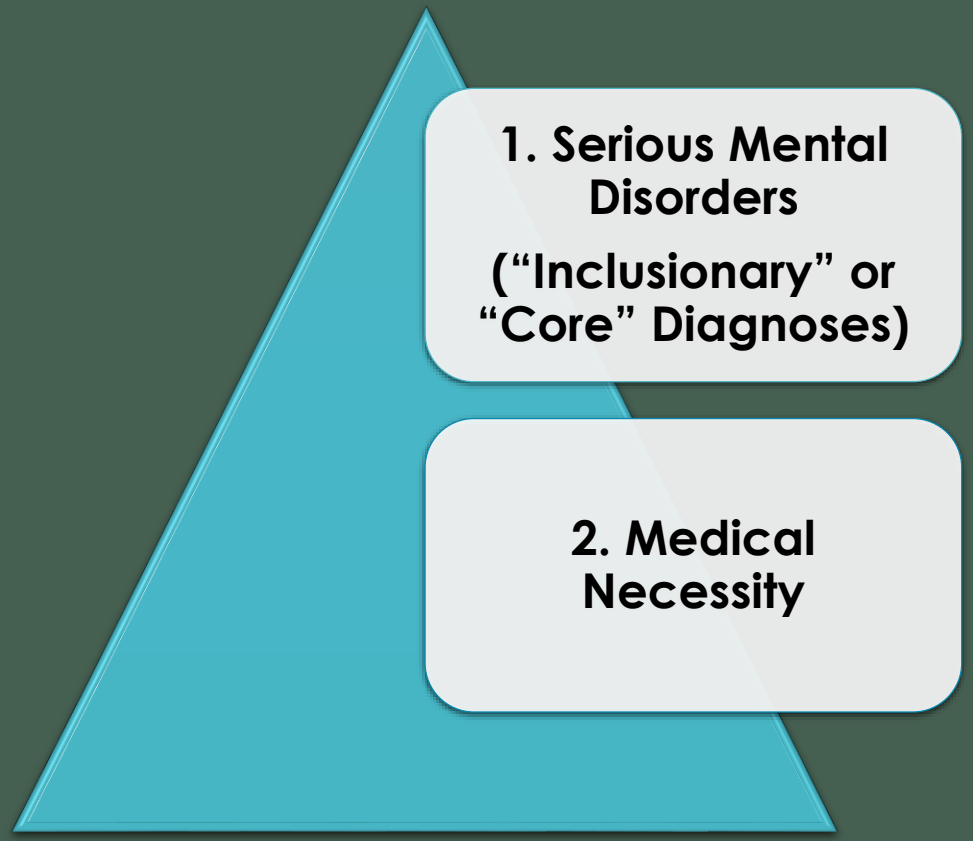
Reception Center Processing

- **ALL INMATES: Initial Health Screening by Nursing**
- **ALL INMATES: Mental Health screening**
- **ALL INMATES who need it: More Comprehensive Mental Health Evaluation**
- **MH Interview for all inmates who request one**
- **Any Reception Center staff may refer an inmate for clinical interview**

Reception Center Processing

- All interviews in a private setting
- Provisional Diagnosis; level of functioning; Level of Care (LOC)
- Services provided to inmates while awaiting transfer
- RC's report data on all inmates screened who have treatment needs

Overall Treatment Criteria



Inclusionary (Core) Treatment Criteria for MHSDS

- Schizophrenia
- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizoaffective Disorder
- Substance-Induced Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition
- Psychotic Disorder NOS (DSM-IV-TR: Note: DSM-5 are found in the EHRS, but the policy change is in process)
- Bipolar Disorder
- Major Depressive Disorder

Medical Necessity Treatment

When necessary to protect life and/or treat significant disability/dysfunction

Individual has a mental health disorder not previously mentioned

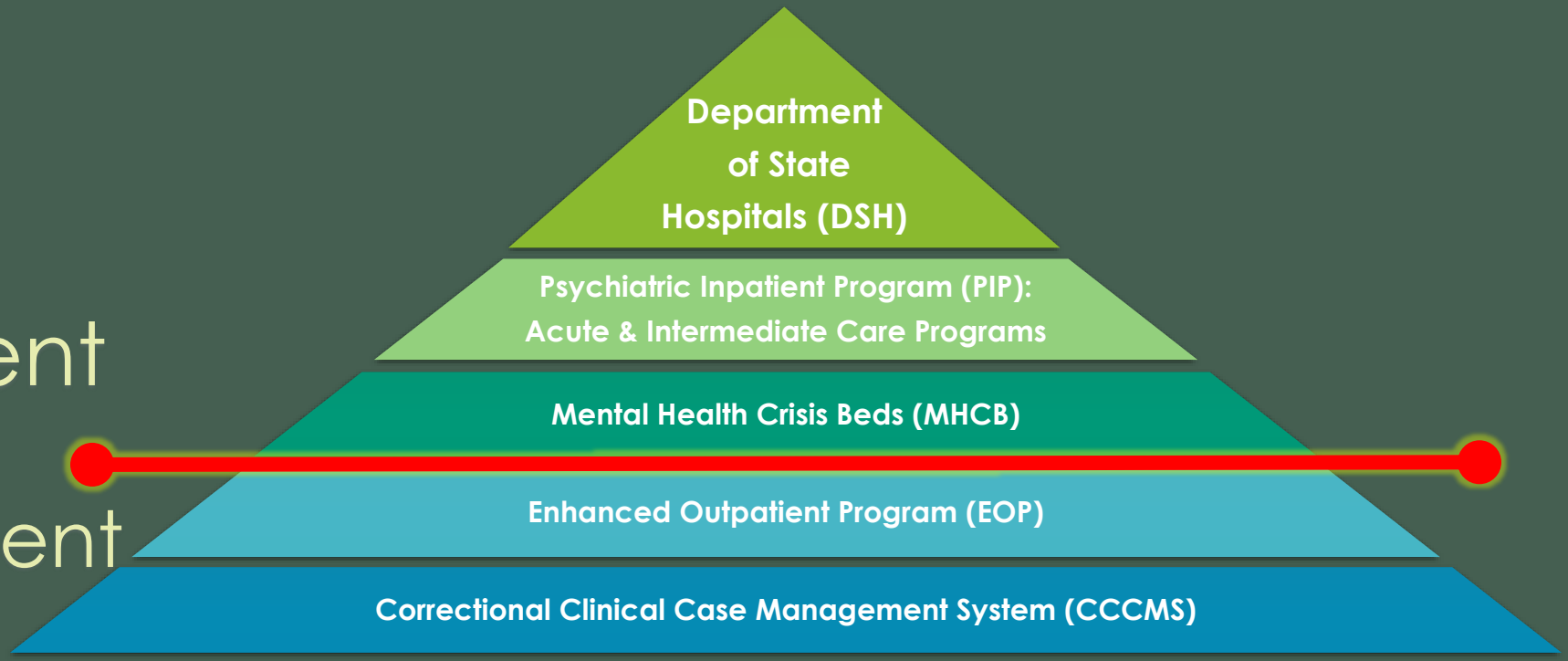
Examples of Medical Necessity Diagnostic Issues

- All anxiety-related disorders including Seasonal Anxiety Disorder, General Anxiety Disorder, & Panic Disorder
- Obsessive-Compulsive Disorders
- Post Traumatic Stress D/O (& other stress disorders)
- Severe personality disorders
- Adjustment disorders
- Taking prescribed psychiatric medications w/out qualifying diagnosis

Levels of Patient Care

Inpatient

Outpatient



LEARNING OBJECTIVE 2

Enhanced Outpatient Program (EOP)

Provide an overview of the Enhanced Outpatient Program (EOP), its purpose, its functions, treatment issues, and treatment services offered

Goal of The EOP

- To provide focused evaluation and treatment of mental health conditions which are limiting an inmate's ability to adjust to a GP placement.
- The overall aim is to provide clinical intervention to return the individual to the least restrictive clinical and custodial environment.

EOP Provision of Care

- Acute Onset or Significant Decompensation of a serious mental disorder characterized by:
  - Increased delusional thinking,
  - Hallucinatory experiences,
  - Marked changes in affect, and
  - Vegetative signs with definite impairment of reality testing and/or judgment

and/or (cont'd on next slide)

EOP Provision of Care When…

- Inability to function in the General Population
- A demonstrated inability to program in work or educational assignments or other correctional activities…. is present
- There is a presence of dysfunctional or disruptive social interaction including withdrawal, bizarre or disruptive behavior, extreme argumentativeness…due to a mental disorder
- An impairment in the activities of daily living (e.g., eating, grooming & personal hygiene, maintenance of housing area, ambulation) as a result of a serious mental disorder or a Personality Disorder (as described in an official review from 2017).

Sources of Referrals to EOP

- Admitted at Reception Centers
- Referred from General Population
- Referred from CCCMS
- Referred from MHCB
- Discharge from PIP or DSH

Examples of EOP Cases

- Patient D is a 60 year old male in EOP LOC. Patient D has been incarcerated for 15 years after murdering another resident at his board and care home. Patient D was in inpatient treatment two years ago for grave disability when he was hoarding old food and flooding his cell. Patient D is often disheveled, malodorous, and his cell is messy. Housing officers on the unit report that they have had to move him to 3 different cells in the last year due to conflicts with cellmates regarding his poor hygiene and desire to sleep most of the day. Patient D is on modified treatment and attends only groups with his primary clinician, but is compliant with his medication and attends church services weekly.
- Patient H is a 34 year old male in the EOP program and has been in the MHSDS at the EOP LOC since his arrival to CDCR 12 years ago. His commitment offenses include burglary and arson. He has a diagnosis of Persistent Depressive disorder. Patient H takes his Zoloft sporadically and has had 6 placements in MHCB for suicidal ideations, last admission was 3 years ago. He does not take his medication on a regular basis because he reports all medications upset his stomach. Patient H's group attendance is usually around 65%, he reports only enjoying his "hands on" recreation therapy groups. Patient H's hygiene is fair, and he has the mental capacity to wash his own laundry. Depending on his mood, his room can be kept clean. Patient H also has diabetes, but due to his depression, he has little energy to exercise and often trades his lunch and dinner for honey buns from his cellmate's canteen.

- Patient S is a 54 year old male incarcerated for several counts of lewd and lascivious acts with a minor and is in MHSDS at the EOP LOC. Patient S is diagnosed with PTSD and Major Depressive Disorder (severe and recurrent). Patient S's primary symptoms include irritability, nightmares, and negative thoughts about himself, others, and his future, as well as excessive guilt. Patient S attends all his individual appointments and is medication compliant. Patient S has a few acquaintances on his housing unit but avoids large group settings. Pt enjoys playing his guitar, reading, and playing solitaire in his cell. Patient S has no recent RVRs, and housing officers report he is usually quiet and keeps to himself. Patient S does not want to go to work and plans to apply for SSI and VA benefits in the community. Patient is apprehensive about transition to CCCMS because he does not want to live in a dorm.

- Patient Y is a 38 year old female in CDCR for threatening staff at a radio station. Patient Y is in EOP due to delusional beliefs that she is the forgotten daughter of Michael Jackson. Patient Y's Master Treatment plan notes she needs some redirection if she begins to share her delusional beliefs. Patient Y can advocate for herself and appears to function in the institution, most days, with little support from staff. Patient Y is not on medication and attends most of her treatment activities. Patient Y is an assigned porter on the unit and does her peer's hair. Patient Y's strengths are her ability to use humor and music to connect with others and according to her PC, she appears to get along well with all different types of inmates in EOP. PT wants to transition to CCCMS but the treatment team is concerned that she has acted out aggressively and decompensated when her delusions were challenged by GP inmates.

The Primary Clinician (PC)

A Licensed Clinical Social Worker, Psychologist, or a Psychiatrist is identified by the Chief of Mental Health (or designee) as the PC for each patient.

The PC assumes overall responsibilities for the treatment services provided to patients by maintaining active therapeutic involvement with the patient.

The PC coordinates services provided by other treatment providers involved in implement the treatment plan.

Clinicians Actively Interface with Custody

- EOP clinicians actively work with custodial staff (including Correctional Counselors, or CCs)
- This enhances the assessment & treatment process
- It also optimizes the patient functioning within the prison environment.

EOP Provides Separate Housing & Structured Activities

- EOP is characterized by a separate housing unit, where majority of institutions house patients in cells, but some also use dorm settings.
- EOP patients are viewed as having difficulties when interacting with the General Population (GP) because of their illness, experiencing adjustment difficulties in a GP setting.
- Treatment is focused on resolution of institutional adjustment problems which impede functioning within the GP.

EOP and Other Levels of Care

- EOP builds a type of bridge between the basic service needs of patients in CCCMS and inpatient treatment.
- However, they are not so impaired as to require 24-hour inpatient care.
- Patients who, because of their mental disorders, do not function well in EOP may be referred for higher levels of care.

Aims of EOP for Most Cases

- Ideally EOP provides short to intermediate term (a range of 3 to 12 months) focused care for patients who do not require 24-hour inpatient care.
- Treatment goals are primarily directed at developing the following:
  - Constructive coping mechanisms
  - Compliance with treatment
  - Further stabilization of psychiatric symptoms that is necessary for transition to CCCMS

Aims of EOP for Patients with Chronic Symptoms

- EOP provides longer-term placement for patients with chronic symptoms of mental illness, whose symptoms have sufficiently stabilized to not necessitate inpatient treatment, but whose level of functioning is insufficient to allow GP placement.

Services include:

- Supportive care
- Assistance with activities of daily living
- Recreation therapy
- Anger management
- Reality therapy
- Programs related to symptom management
- Clinical pre-release planning

Basic EOP Treatment Services

- Interdisciplinary Treatment Teams (IDTT) every 90 days
- Management of activities of daily living
- Individual psychotherapy, weekly
- 10 hours of out-of-cell, structured-therapeutic activities (Group Therapy), weekly
- Medication management/Psychiatric services
- Recreational therapy
- Clinical pre-release planning

Examples of Group Therapy Themes

Daily living skills	Medical education	Symptom management	Focused mental health issues	Social skills
Anger management	Stress management	Substance use	Health issues	Offense-specific
	Rational behavior/reality and decision-making	Family issues	Clinical pre-release groups	

Recreational Therapy

- Recreational therapies provide patients with supervised recreational activities or exercise programs designed to:

Reduce stress

Improve self-esteem & physical health

Foster positive interpersonal interactions

Promote the constructive use of leisure time

Work and School Assignments

- Work & educational programs may provide rehabilitative services through institutional programming designed to help patients improve vocational & educational functioning.
- Work & educational assignments can constitute up to 4 hours of structured activity per week if they are identified as such in the patient's treatment plan.
- The treatment plan must indicate how it is believed the patient benefits from particular vocational and/or educational activities.

Patient's Weekly Schedule

The weekly schedule of a patient is individualized and specific to the mental health needs of the patient.

- Expected to attend 10 hours of MH groups weekly
- Attend 1:1 session with their MH Primary Clinician weekly
- Psychiatrist appointments are as needed but at minimum every 90 days.
  - Take prescribed medications as set by the psychiatrist.
- Attend IDTT every 90 days or as needed.
- Engage in recreational activities, nursing groups, ISUDT groups, etc.

Patient's have work and school privileges that they are able to participate in.

- The IDTT is part of this process to help determine if the patient has the capacity to engage in these activities or the type of work they would be best fit for.
- If the IDTT believes that the patient is not fit for work, the IDTT is expected to develop a treatment goal with the patient.

Modified Treatment Plans

- For patients who are not able to attend 10 hours of out-of-cell activity per week:
  - It may be clinically contraindicated
  - PC shall recommend a modified treatment program to IDTT
  - IDTT must approval plan
  - Rationale must be thoroughly documented in Master Treatment Plan.

Milestone Credits

- EOP patients shall be awarded credit upon successfully completing scheduled, structured therapeutic activities in accordance with their mental health treatment plan in the following increments:
  - One week of credit (the equivalent of seven calendar days) for every 60 hours completed up to a maximum of six weeks of credit for 360 hours completed in a twelve-month period.

EOP Services in Restricted Housing

Ad-Seg EOP Hub

Psychiatric Services Unit (PSU)

LEARNING OBJECTIVE 3

Briefly describe the core components and tasks of the Interdisciplinary Treatment Team (IDTT) and Level of Care changes

Members of the IDTT

Mandatory

- Patient
- Assigned Primary Clinician
- Assigned Psychiatrist
- Correctional Counselor

Optional

- Nursing
- Recreation Therapists
- Teachers
- Supervisors
- Custody Officers
- Others

IDTT & Treatment Plans

- IDTT is generally responsible for developing & updating the Master Treatment Plan, which contains
  - Input from patient
  - Other pertinent clinical information that may indicate the need for a different level of care (LOC)
  - Referrals to high LOCs are considered when the patient's clinical condition has worsened or the patient is not benefiting from treatment services available at the current LOC.

IDTT and Case Review

- IDTT is responsible for conducting a structured process of case review occurring at least quarterly, or more often if clinically indicated.
- Purpose of the review is to optimize progress towards achieving resolution of symptomatology sufficient for placement in the least restrictive clinical and custodial environment. Proper case review maximizes the utilization of the limited beds available for EOP placements.
- Mental Health is also involved with custodial classification committees for patients in EOP.

Determining the Efficacy & Appropriateness of the Patient's LOC

- In consultation with the IDTT, a full review (which includes the following) is done of patient's treatment progress to determine the efficacy of the current treatment plan and the appropriateness of the EOP LOC:
  - Current clinical status
  - Performance in work,
  - Performance in educational & vocational training
  - Performance in social & daily living activities

Case Reviews & Changes in LOC

- Case reviews are done every time placement in more intensive LOC or change to non-patient status is indicated.
- Custody staff who manage the patient's day-to-day routine are included whenever possible in the IDTT.
- PCs document the presence or absence of the patient during the review & indicate reasons for the patient's absence, when appropriate.

Summary of Discharge Types from EOP

- Discharge from the EOP is based upon a decision utilizing the IDTT process when the patient satisfies any of the following conditions:
  - Is able to function in a GP setting with CCCMS support
  - Has clinically decompensated to the extent that placement into an inpatient program (MHCB, PIP or DSH) is required
  - Has reached their parole date, and clinical services will be transferred to a BHR (CDCR community mental health treatment).

Possible Reasons a Patient Will "Graduate" from EOP

- Patient has been off of medications and presents as stable.
- Patient has been able to maintain participation in several rehabilitative programs with little to no issues.
- Patient has attended the majority of groups offered and has reached the maximum benefit.
- Patient has been able to display adequate functioning despite minimal treatment compliance.
- Patient's symptoms have significantly decreased over time.

Possible Reasons a Patient Does Not "Graduate" in 12 months

- Patient symptoms have worsened.
- Patient would be at risk for victimization if placed at a lower level of care.
- Patient continues to receive RVRs due to mental illness.
- Patient has a serious suicide attempt or self-injury.
- Patient has not been stabilized on medication.
- Patient is resistant to transitioning to a LOC and team is working with patient on a transition plan.
- Cultural/Institutional barriers

LEARNING OBJECTIVE 4

Discuss Pre-Release Planning for patients in the EOP

EOP Pre-Release Planning

- Can be discussed during individual treatment
- Institution may offer pre-release planning groups within their EOP program.
- Patient may reach out to traditional pre-release services offered to all inmates at that institution.

Pre-Release Group Discussions

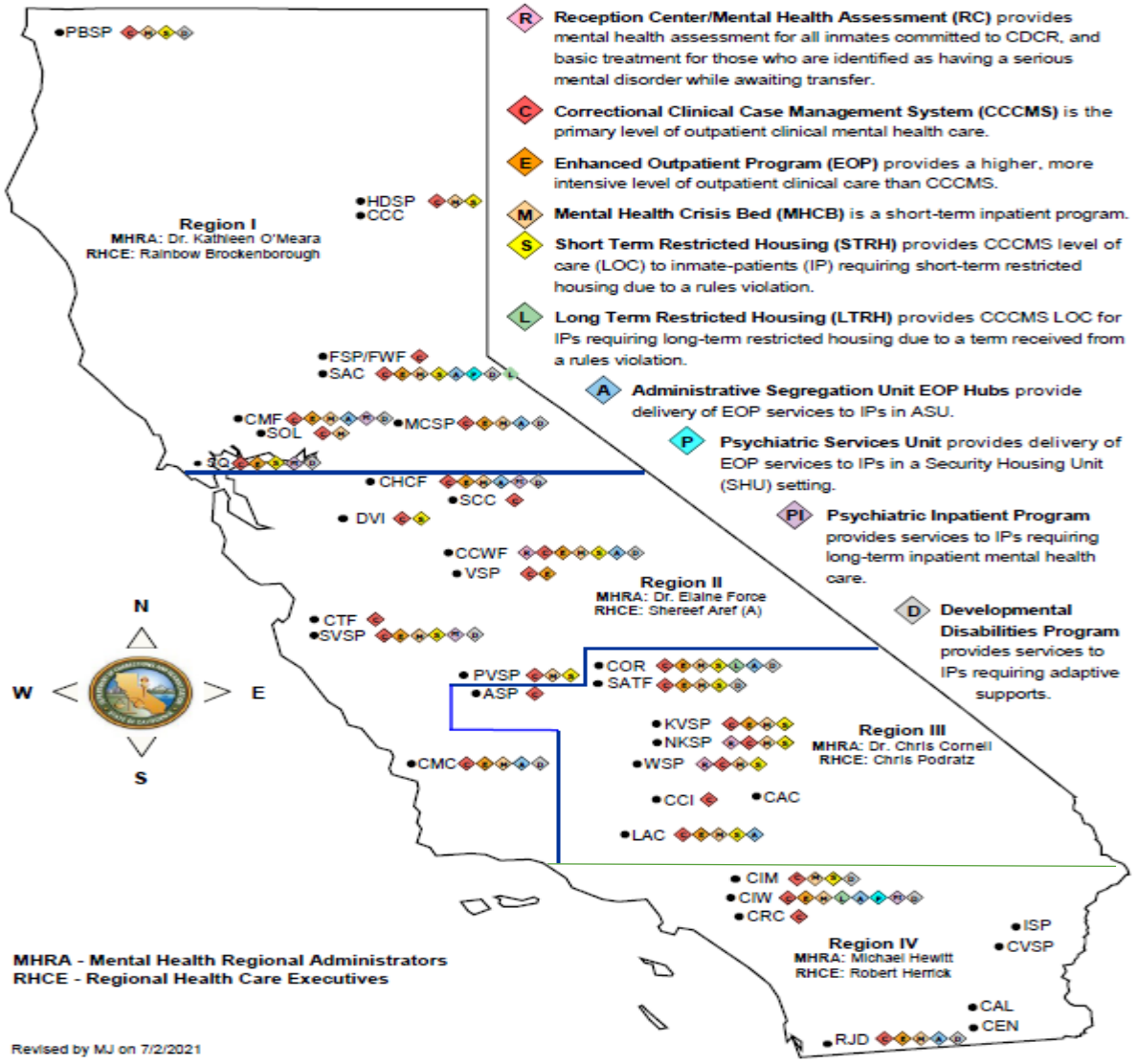
Weekly groups that discuss issues related to community living, including

- Living arrangements
- Continued outpatient care
- Financial issues
- Educational issues
- Vocation needs

EOP Clinical Pre-Release Program

- EOP patient's will usually get this level of support until after a contingent parole board approval.
- Clinical staff will provide patients in EOP with imminent (60-120 days) release dates the following:
  - Application for federal & state benefit entitlements, such as: Medi-Cal, Medicare, SSI, & Veterans' Benefits
  - Eligible inmates referred to the Transitional Case Management (TCMP)
  - Initiation of Conservatorship proceedings
  - Liaison with Parole Outpatient Program staff
  - Liaison with family members & significant others who may provide living options
  - Screening for need of inpatient placement per Penal Code 2962 (MDO)

California Department of Corrections and Rehabilitation
Division of Health Care Services
Mental Health Services Delivery System Map



THANK YOU!

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